Section III

APPENDICES

FAMILY SUPPORT SERVICES SPECIALIZED EQUIPMENT DEFINITIONS{tc "Specialized Equipment Definitions" \l 2}

I. ADAPTIVE AIDS

Devices, controls or appliances which enable persons to increase their abilities to perform activities of daily living or control the environment in which they live.

1. Patient lifts
    a. Van lifts/adaptations
    b. Lift devices
    c. Standing boards/frames/wheelchairs

2. Control Switches/Pneumatic Switches and Devices
    a. Sip and puff controls
    b. Adaptive switches/devices

3. Environmental Control Units
    a. Locks
    b. Electronic control units
    c. Safety restraints

II. COMMUNICATION AIDS

Those devices or services necessary to assist persons with hearing, speech, or vision impairment to be able to effectively communicate with service providers, family, friends and to the general public.

1. Communicators (including repair and maintenance)
    a. Direct selection communicators
    b. Alphanumeric communicators
    c. Scanning communicators
    d. Encoding communicators

2. Speech amplifier, aids and assistive devices (and maintenance)

3. Interpreters

III. LIMITS AND EXCLUSIONS

All adaptive aids costing in excess of $500.00 require documentation from a rehabilitation organization or Occupational or Physical Therapist that the purchase is appropriate to the individual served.

All communication aids costing in excess of $500.00 require documentation from a rehabilitation organization, a licensed Speech Therapist or Speech Pathologist, assuring the need for the service.

IV. STANDARDS

Adaptive and communication aids must meet Underwriter's Laboratory of Federal Communications Commission Standards where applicable.

Family Support Waiver Request{tc "Family Support Waiver Request" \l 2}

Identifying Information:

Date:_____ Region:_____

Staff Contact:_____ Phone: _____

Client Name: _____

Client SS#:_____ DOB: _____

Parent(s)/Primary Caretaker:

Name:_____ Age: _____

Name:_____ Age: _____

Address: _____

Telephone: # (Home)_____ (Work)_____

Request is to Waive: (Check One)

_____ Income Eligibility (Local decision.)
_____ Categorical or Diagnostic Eligibility
_____ Pre-Authorized List of Goods and Services (Other Services)
_____ Rate (Amount of good or service exceeds annual rate by more than 50%)
_____ Other (Explain)

Justification: (Explain fully, i.e. why the particular requested waiver should be granted based on the needs of the individual/family, what is the intended impact of the requested waiver on the individual/family, why Family Support funds are necessary based on the availability or lack thereof of individual/family and community or other resources. Attach documentation that supports justification.)

Service(s)/Product(s):

Item Total Cost Cost Per Unit

Total Cost (all Items) _____.....

DHR: DMHDDAD: REGIONAL MHDDAD OFFICE

[ ] Approved [ ] Disapproved

By:_____ Date: _____

Remarks: _____

Family Support Agreement

_____ ("Applicant") has submitted an application on behalf of the family of _____("Consumer") for Family Support services, and _____ ("Provider"), a Family Support Provider contracting with DMHDDAD Region _____, has agreed to provide certain services. This is an agreement between Applicant, on behalf of Consumer and his/her family (as defined in the Family Support Operating Procedures) The family is eligible only if the member with disabilities is residing in the home, or if the Family Support funds are to be used to prepare the home and family for the return of the member with disabilities from an alternate care placement, and Provider regarding Family Support Services.

Applicant agrees as follows:

- Applicant understands and acknowledges that Family Support services are provided only in the event that such services are not available or cannot be funded through other programs (including but not limited to Medicaid, Medicare, charitable organizations, etc.)

- Applicant has provided complete and accurate information to Provider regarding Applicant's and Consumer's efforts to obtain services through other programs, and regarding Applicant's and Consumer's financial and other resources and needs. Applicant represents that no other resources are available for the services Applicant has requested as Family Support.

- Applicant represents that all money received through Family Support services will be used solely for the purpose(s) documented on the Applicant's Individual Family Service Plan. The Applicant understands and acknowledges that Family Support funds cannot be advanced to the Applicant or to any provider of services under any circumstances.

- Applicant understands and acknowledges that he/she must present receipts or other documentation to verify any expenses for which he/she requests payment or reimbursement. Any misrepresentations of expenses or other attempt to misappropriate these funds is strictly prohibited and is subject to legal action.

- Applicant understands and acknowledges that any misrepresentation of Applicant's/Consumer's needs, resources, efforts to obtain services elsewhere, expenses incurred as part of the Family Service Plan (Annex A). and any attempt to misappropriate Family Support funds will result in immediate discontinuation of services, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) or misappropriation(s).

- Applicant understands and acknowledges that any individual providing respite services as part of Family Support must be on a region maintained "Registry of Approved Respite Providers" prior to providing any respite services. (They cannot be reimbursed for any services provided prior to being placed on the registry.) In order to be placed on the registry, respite service providers must provide the region with proof of certification, in Cardiopulmonary Resuscitation (CPR) and documentation has to be received by the region that the applicant has satisfactory passed a criminal records background check.

- Applicant understands and acknowledges that Family Support services are neither an entitlement nor a grant, and are provided as services to assist in maintaining a cohesive family unit and to assist the Consumer to live at home in the community. The continued need for Family Support services will be re-evaluated no less than every six months.

- Applicant agrees to use the Family Support services in compliance with all applicable guidelines (Attached hereto as Annex B).

Provider agrees as follows:

- Provider will develop an Individual Family Support Plan (IFSP) for Applicant and Consumer. Provider will develop the IFSP in consultation with Applicant and, to the extent possible, with Consumer.
- Provider will set fees for Family Support goods and services on a "sliding fee" basis in consideration of Applicant's resources, and in compliance with applicable DHR fiscal rules and regulations.
- Provider will designate a Family Support Coordinator as a single point of contact to work with Applicant and Consumer in obtaining Family Support.
- Provider will review the IFSP every six (6) months, and at such time as there has been a significant change in Applicant's/Consumer's resources or needs.
- Provider will inform Applicant in writing of Applicant's rights to participate in the IFSP and IFSP reviews, and to appeal a denial, discontinuance, or reduction in benefits.

Both parties agree as follows:

- Provider and Applicant will sign both copies of this agreement and return one signed copy to the appropriate MHDDAD Regional Office.
- This Agreement contains the entire agreement of the parties and there are no other promises or conditions in any other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the parties.
- This Agreement may not be amended or modified except in writing signed by both parties.

- The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.
- This Agreement is a required part of the Individual Family Support Plan; no Family Support funds may be expended prior to both parties' signing this Agreement.
- This agreement will terminate upon written notice of either party.

_____
Printed Name of Consumer

_____ _____
Printed Name of Applicant Relationship to Consumer

_____ _____
Signature of Applicant Date

_____

_____

_____
Applicant's address

_____
Provider Agency

_____
Printed name and title of Provider Official

_____ _____
Provider Official signature Date

_____

_____

_____
Provider's address